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| **Department of Veterans Affairs** | | | | **REQUEST FOR PHYSICAL EXAMINATION** | | | | | | | | | | | |
| NOTE; Shaded items are not to be completed by originator. | | | | | | | | | | | | | | | |
| 1. NAME | 2. FILE NUMBER | | 3. SOC. SEC. NO. | | | | 4. DATE OF BIRTH | | 5. SEX | 6. PERIOD OF SERVICE | | | | | 7.CONTROL DATE |
|  | EOD | | | RAD | |  |
| 8A. FIRST NAME-MIDDLE INITIAL-LAST NAME OF VETERAN | | | | | 8B. ADDRESS OF VETERAN  *(STREET, CITY, STATE AND ZIP CODE)* | | | | | | | 8C. DAYTIME TELEPHONE NO. OF VETERAN *(INCLUDE AREA CODE)* | | | |
| 9. REGIONAL OFFICE ADDRESS | | | | | | | | | | | | | | | |
| 10. RECEIVING STATION ONLY | | | | | | | | | | | | | | | |
| A. DATE OF RECEIPT | | B. DATE SCHEDULED OR AUTHORIZED | | | | | | C. DATE COMPLETED | | | | | | D. PLACE OF EXAMINATION  CLINIC FEE OTHER STATION | |
| E. NAME OF FEE EXAMINER OR OTHER STATION | | | | | | | | | | | | | | | |
| 11. PRIORITY OF EXAMINATION (CHECK APPROPRIATE BOX(ES))  TERMINAL POW ORIGINAL (S.C.)  REVIEW OTHER(SPECIFY) | | | | | |  | ORIGINAL (N.S.C.) | | | | INCREASED OR REOPENED | | | | |
| 12. PLEASE CONDUCT:  A. A COMPLETE GENERAL MEDICAL EXAMINATION WITH SPECIAL ATTENTION TO DISABILITIES LISTED IN ITEM 13  B. AN EXAMINATION LIMITED TO DISABILITIES LISTED IN ITEM 13 | | | | | | | | | | | | | | | |
| 13. REMARKS *(LIST DIAGNOSES OR SYMPTOMS FOR WHICH EXAMINATION IS REQUIRED)* | | | | | | | | | | | | | | | |
| 14. CLAIMANT REPRESENTED BY  AL AMVETS DAV JWV MOPH | | | | | | PVA | VFW OTHER *(SPECIFY)* | | | |  | | | | |
| 15. DATE | | | 16. SIGNATURE OF AUTHORIZING OFFICIAL | | | | | | | | | 17. SYMBOL AND BOARD NO. | | | |

VA FORM OCT. 2003

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